Filing at a Glance

Company:	Liberty Life Assurance Company of Boston
Product Name:	Life Application (Whole Life, Term, and UL)
State:	Arkansas
TOI:	L07I Individual Life - Whole
Sub-TOI:	L07I.101 Fixed/Indeterminate Premium - Single Life
Filing Type:	Form
Date Submitted:	12/20/2012
SERFF Tr Num:	LLAC-128822246
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	APP-2012139 & APP-2012139-O
Implementation Date Requested:	On Approval
Author(s):	Andrew Baron, Margaret Gallagher, Lindsey Boisvert, Aimee Belliveau
Reviewer(s):	Linda Bird (primary)
Disposition Date:	01/03/2013
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: Arkansas **Filing Company:** Liberty Life Assurance Company of Boston
TOI/Sub-TOI: L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life
Product Name: Life Application (Whole Life, Term, and UL)
Project Name/Number: /

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Lindsey Boisvert

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 01/03/2013
State Status Changed: 01/03/2013
Created By: Lindsey Boisvert
Corresponding Filing Tracking Number:

Filing Description:
Dear Reviewer,

The above referenced forms are being submitted for your review and approval. These forms are new and will not replace any forms currently on file with the Department.

Form APP-2012139 is an Application for Individual Life Insurance that will be used in the sale of the following individual life insurance products (Whole Life, Term and Universal Life) offered by the Company.

Form APP-2012139 will also be used in the sale of other individual life insurance products offered by the Company, as applicable.

Form APP-2012139 is intended to be used with any approved supplemental applications, as applicable. Currently, form APP-2012139-O is the only supplemental application available with form APP-2012139.

Form APP-2012139-O is a Supplemental Application for Individual Life Insurance that will be used with form APP-2012139, APP-2012254 or other applications as applicable. Form APP-2012254 is being submitted in a separate filing.

Form APP-2012139-O will be used when space is necessary for additional information.

The applicant replacement questions appear on form APP-2012139. We will obtain the agent replacement question on a separate administrative form. See certification in Supporting Documentation.

The applications can be completed in paper or using an electronic system that facilitates completion. If using the electronic completion process, there will be prompts to provide additional details where required. Signatures will be paper-based.

Variable information is described in a Statement of Variability for each form.

Company and Contact

Filing Contact Information

Lindsey Boisvert, Senior Product and Contract Analyst
100 Liberty Way
Dover, NH 03820

lindsey.boisvert@libertymutual.com
800-451-7065 [Phone] 36015 [Ext]
603-472-0796 [FAX]

State: *Arkansas* ***Filing Company:*** *Liberty Life Assurance Company of Boston*
TOI/Sub-TOI: *L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name: *Life Application (Whole Life, Term, and UL)*
Project Name/Number: */*

Filing Company Information

Liberty Life Assurance Company of Boston
100 Liberty Way
Dover, NH 03820
(800) 451-7065 ext. [Phone]

CoCode: 65315
Group Code: 111
Group Name: Liberty Mutual
FEIN Number: 04-6076039

State of Domicile: New Hampshire
Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	Yes
Fee Explanation:	$50 per form x 2 forms
Per Company:	No

Company	Amount	Date Processed	Transaction #
Liberty Life Assurance Company of Boston	$100.00	12/20/2012	65946088

SERFF Tracking #:	*LLAC-128822246*	***State Tracking #:***		***Company Tracking #:***	*APP-2012139 & APP-2012139-O*

State:	*Arkansas*	***Filing Company:***	*Liberty Life Assurance Company of Boston*
TOI/Sub-TOI:	*L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life*		
Product Name:	*Life Application (Whole Life, Term, and UL)*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/03/2013	01/03/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Linda Bird	12/20/2012	12/20/2012

Response Letters

Responded By	Created On	Date Submitted
Lindsey Boisvert	12/20/2012	12/20/2012

SERFF Tracking #:	*LLAC-128822246*	***State Tracking #:***		***Company Tracking #:***	*APP-2012139 & APP-2012139-O*

State:	*Arkansas*	***Filing Company:***	*Liberty Life Assurance Company of Boston*
TOI/Sub-TOI:	*L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life*		
Product Name:	*Life Application (Whole Life, Term, and UL)*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 01/03/2013
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Replacement Question Certification		Yes
Form	Application for Individual Life Insurance		Yes
Form	Supplemental Application for Individual Life Insurance		Yes
Form	Statement of Variability		Yes
Form	Statement of Variability		Yes

State: *Arkansas* **Filing Company:** *Liberty Life Assurance Company of Boston*
TOI/Sub-TOI: *L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name: *Life Application (Whole Life, Term, and UL)*
Project Name/Number: */*

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/20/2012
Submitted Date	12/20/2012
Respond By Date	01/21/2013

Dear Lindsey Boisvert,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

Comments: Regulation 57 was revised effective January 2010, the filing fee is now $50.00 per form. We will hold your filing in a pending status until the additional $50.00 filing fee is received.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Linda Bird

State: Arkansas **Filing Company:** Liberty Life Assurance Company of Boston
TOI/Sub-TOI: L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life
Product Name: Life Application (Whole Life, Term, and UL)
Project Name/Number: /

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	12/20/2012
Submitted Date	12/20/2012

Dear Linda Bird,

Introduction:

Thank you for your response.

Response 1

Comments:

Per our telephone conversation today, the filing fee submitted is $100 and acceptable as is.

Related Objection 1

Comments: Regulation 57 was revised effective January 2010, the filing fee is now $50.00 per form. We will hold your filing in a pending status until the additional $50.00 filing fee is received.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Thank you,
Lindsey Boisvert
Sincerely,
Lindsey Boisvert

SERFF Tracking #:	*LLAC-128822246*	***State Tracking #:***		***Company Tracking #:***	*APP-2012139 & APP-2012139-O*

State:	*Arkansas*	***Filing Company:***	*Liberty Life Assurance Company of Boston*
TOI/Sub-TOI:	*L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life*		
Product Name:	*Life Application (Whole Life, Term, and UL)*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: APP-2012139

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Application for Individual Life Insurance	APP-2012139	AEF	Initial		54.600	APP-2012139 Rev 09-12 Bracketed.pdf
2		Supplemental Application for Individual Life Insurance	APP-2012139-O	AEF	Initial		52.900	APP-2012139-O Bracketed.pdf
3		Statement of Variability	APP-2012139	OTH	Initial			Statement of Variability APP-2012139.pdf
4		Statement of Variability	APP-2012139-O	OTH	Initial			Statement of Variability APP-2012139-O.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate

SERFF Tracking #:	*LLAC-128822246*	***State Tracking #:***		***Company Tracking #:***	*APP-2012139 & APP-2012139-O*

State:	*Arkansas*	***Filing Company:***	*Liberty Life Assurance Company of Boston*
TOI/Sub-TOI:	*L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life*		
Product Name:	*Life Application (Whole Life, Term, and UL)*		
Project Name/Number:	*/*		

POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

Liberty Life Assurance Company of Boston
Service Center, 100 Liberty Way, Dover, NH 03820

Contract number _____ (Home office use only)

Application for Individual Life Insurance

1. PROPOSED INSURED

Name (First, Middle, Last) _____ ☐ Male ☐ Female

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

Telephone number _____ Email _____

Birth date _____ ☐ Backdate to save age Birthplace (State, Country) _____

Social Security number _____ Driver License number _____

Are you a United States citizen? ☐ Yes ☐ No If "No," type of Visa _____

Employer name _____ Employer telephone number _____

Employer address (Street, City, State, ZIP) _____

Occupation (Include duties) _____

Annual earned income $ _____ Other income (Include source) $ _____ Net worth $ _____

2. OWNER

☐ Select if same as insured.

Name (First, Middle, Last)/Entity _____

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

Telephone number _____ Email _____ Birth/Trust date _____

Social Security/Tax ID number _____ Relationship to insured _____

Are you a United States citizen? ☐ Yes ☐ No If "No," type of Visa _____

3. JOINT OWNER

Complete if applicable.

Name (First, Middle, Last)/Entity _____

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

Telephone number _____ Email _____ Birth date _____

Social Security/Tax ID number _____ Relationship to insured _____

Are you a United States citizen? ☐ Yes ☐ No If "No," type of Visa _____

4. ALTERNATE ADDRESSEE

You may authorize an alternate addressee to receive past due premium notices. (Optional Section)

Name (First, Middle, Last) _____

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

5. PAYOR

☐ Select if same as owner. ☐ Select if same as insured.

Name (First, Middle, Last)/Entity _____

Residence address (Street, City, State, ZIP) _____

Mailing address (If different) _____

Telephone number _____ Email _____

Social Security/Tax ID number _____ Relationship to insured _____

Please complete if payor rider is selected. (Payor rider is applicable for Whole Life plans only.)

Birth date _____ Birthplace (State, Country) _____ ☐ Male ☐ Female

Height (ft, in) _____ Weight (lbs) _____ Driver License number _____

Contract number ____________________
(Home office use only)

6. BENEFICIARIES

All designated beneficiaries will be considered primary, sharing equally, unless otherwise indicated.

☐ Primary ☐ Contingent ________% Relationship to insured ____________________

Name (First, Middle, Last)/Entity ____________________ Birth/Trust date __________

Residence address (Street, City, State, ZIP) ____________________

Mailing address (If different) ____________________

Telephone number ____________________ Social Security/Tax ID number ____________________

☐ Primary ☐ Contingent ________% Relationship to insured ____________________

Name (First, Middle, Last)/Entity ____________________ Birth/Trust date __________

Residence address (Street, City, State, ZIP) ____________________

Mailing address (If different) ____________________

Telephone number ____________________ Social Security/Tax ID number ____________________

☐ Primary ☐ Contingent ________% Relationship to insured ____________________

Name (First, Middle, Last)/Entity ____________________ Birth/Trust date __________

Residence address (Street, City, State, ZIP) ____________________

Mailing address (If different) ____________________

Telephone number ____________________ Social Security/Tax ID number ____________________

7. CHILDREN'S PROTECTION

"Children" means all children, step-children, and legally adopted children of the Insured who have not reached their 18th birthday. Insurance will not be provided on any child until 15 days after birth.

Name (First, Middle, Last) ____________________ ☐ Male ☐ Female

Birth date __________ Birthplace (State, Country)__________ Height (ft, in) ______ Weight (lbs) ______

Name (First, Middle, Last) ____________________ ☐ Male ☐ Female

Birth date __________ Birthplace (State, Country)__________ Height (ft, in) ______ Weight (lbs) ______

Name (First, Middle, Last) ____________________ ☐ Male ☐ Female

Birth date __________ Birthplace (State, Country)__________ Height (ft, in) ______ Weight (lbs) ______

Name (First, Middle, Last) ____________________ ☐ Male ☐ Female

Birth date __________ Birthplace (State, Country)__________ Height (ft, in) ______ Weight (lbs) ______

8. COVERAGE/REPLACEMENT

	Yes	No
a) Is there any life insurance or annuity applied for or in force, other than group insurance, for the proposed insured? (If applicable, complete and submit replacement forms.)	☐	☐
Total life insurance in force $ __________ Total Accidental Death Benefit $ __________		
b) Will this contract replace any existing life insurance or annuity in this or any other company?	☐	☐
If "Yes," replaced policy type ☐ Life ☐ Annuity ☐ Select if Section 1035 exchange		
Company name __________ Contract number __________		
c) Does the proposed owner intend to sell, or transfer ownership of a contract issued as a result of this application? If "Yes" provide details below.	☐	☐
d) Has the proposed owner entered into an agreement, or discussed any arrangement, for the sale or transfer of a contract issued as a result of this application? If "Yes" provide details below.	☐	☐

Coverage/Replacement Details

Question # Details

____

____

Contract number _____ (Home office use only)

9. PRODUCT SELECTION

Select one product.

Term

Select one ☐ 10 year ☐ 15 year ☐ 20 year ☐ 30 year | Face amount $_____

Riders ☐ Children's Protection $ _____ ☐ Accidental Death and Dismemberment $ _____
☐ Disability Waiver of Premium

Universal Life

Select one ☐ Spirit Series Universal Life ☐ Spirit Series Performance Universal Life

Face amount $_____ | Modal Planned Premium amount $_____ | Mode _____

Death Benefit Option –Available for Spirit Series Performance Universal Life only. Select one
☐ Option 1 ☐ Option 2 ☐ Option 3

Riders ☐ Children's Protection $ _____ ☐ Accidental Death and Dismemberment $ _____
(Complete Children's Protection section if elected)
☐ Disability Waiver of Monthly Deduction
☐ Disability Waiver of Specified Amount

Whole Life

Select one ☐ Whole Life ☐ Whole Life Paid up at age 65
☐ 20 Payment Whole Life ☐ Extra Value Whole Life _____%_____% | Face amount $_____

Contract Credits ☐ Paid-up Additions ☐ Accumulate at Interest ☐ One-Year Term
☐ Reduce Premiums ☐ Cash

Riders ☐ Children's Protection $ _____ ☐ Disability Waiver of Premium
(Complete Children's Protection section if elected)
☐ Payor Disability and Death
☐ Guaranteed Insurability Option $ _____ ☐ Accidental Death and Dismemberment $ _____

Do you elect Automatic Premium Loan? ☐ Yes ☐ No

10. INITIAL PAYMENT

Select an initial payment mode.

Premium payment $_____

☐ One time Electronic Funds Transfer (EFT) ☐ Credit Card ☐ 1035 Exchange
☐ Check ☐ Payroll deduction ☐ Other _____

One time EFT - Complete if one time EFT was elected for initial payment.

Bank account owner name _____ Bank name _____

Routing number _____ Bank account number _____

Credit card - Complete if credit card was elected for initial payment.

Type of credit card ☐ MasterCard ☐ Visa ☐ Discover

Name on Credit Card _____

Credit Card Number _____ Expiration date _____

11. SUBSEQUENT PAYMENT

Select a subsequent payment mode.

☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly EFT ☐ Payroll deduction Other _____

Monthly EFT - ☐ Select if same as initial payment one time EFT information.

☐ Select if monthly draft date is issue day

Monthly draft day (1^{st}–28^{th}) _____

Bank account owner name _____ Bank name _____

Routing number _____ Bank account number _____

Payroll Deduction - Complete if payroll deduction was elected for initial or subsequent payment.

Client name _____ Client # _____

Member group name _____ Employee account # _____

[Contract number _____ (Home office use only)]

12. PHYSICIAN INFORMATION

[Please provide physician information for proposed insured and any other insured(s).]

Physician name _____ Facility name _____

Mailing address _____ Telephone number _____

Date and reason last seen _____

Physician of (provide insured's name) _____

13. QUALIFYING INFORMATION

[Provide complete details to all "Yes" answers in the Details section below.]

	Proposed Insured		Any Other Insured(s)	
a) Proposed insured Height (ft, in) _____ Weight (lbs) _____	**Yes**	**No**	**Yes**	**No**
b) In the last 6 months, has the proposed insured been medically advised to have any surgery, hospitalization, treatment or test that was not completed, excluding those tests related to the Human Immunodeficiency Virus (AIDS Virus)?	☐	☐	☐	☐
c) Has the proposed insured ever used any form of tobacco or nicotine products? (If "Yes," indicate date last used below.)	☐	☐	☐	☐
Has any proposed insured been diagnosed with or treated within the past 10 years by a licensed member of the medical profession for any of the following diseases or illnesses:				
d) Chest pain, heart attack, high blood pressure, high cholesterol, heart murmur, irregular heartbeat, pacemaker, stroke, mini-stroke, heart valve disease, aneurysm, peripheral vascular disease, carotid artery disease or any other disease of the heart or circulatory system?	☐	☐	☐	☐
e) Diabetes, pre-diabetes, glucose intolerance, or metabolic syndrome?	☐	☐	☐	☐
f) Cancer, tumor, leukemia, lymphoma or melanoma, other than basal cell skin cancer?	☐	☐	☐	☐
g) Emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, asthma, pulmonary embolism or any other disease of the respiratory system?	☐	☐	☐	☐
h) Ulcerative colitis, Crohn's disease, hepatitis, kidney dialysis or any other disease of the digestive or urinary systems?	☐	☐	☐	☐
i) Seizures, paralysis, amputation, fainting, muscle weakness, Parkinson's disease, cerebral palsy, multiple sclerosis, Alzheimer's disease, dementia or any other disease of the brain or nervous system?	☐	☐	☐	☐
j) Lupus, anemia, blood clots, infection with Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS) or any other disease of blood or immune system?	☐	☐	☐	☐
k) Mental retardation, autism or Down syndrome?	☐	☐	☐	☐
l) Major depression, bipolar disorder, schizophrenia, or alcohol or drug dependency or abuse?	☐	☐	☐	☐
Has the proposed insured:				
m) collected or applied for disability or workers compensation benefits in the past 12 months?	☐	☐	☐	☐
n) within the past 3 years, engaged in, or plan to engage within the next 2 years in flying as a pilot, student pilot or crew member? (If "Yes," please complete Aviation Questionnaire.)	☐	☐	☐	☐
o) within the past 5 years, had license suspended or revoked or been convicted of reckless driving or driving under the influence of alcohol or drugs (DUI)?	☐	☐	☐	☐
p) within the past 5 years, used or been convicted of using illegal drugs, used prescription drugs other than directed, been convicted of a felony, or been on probation or parole?	☐	☐	☐	☐
q) ever had any application for life or health insurance declined, postponed or approved other than as applied for?	☐	☐	☐	☐

14. DETAILS

[Provide details here to any qualifying information questions answered "Yes."]

Question #/Insured name	Details/Diagnosis/ Condition/Dates	Medication/Treatments	Physician name

Contract number _____ (Home office use only)

FULLY UNDERWRITTEN & UNIVERSAL LIFE
Complete this page and continue to signature page

SIMPLIFIED ISSUE
Do not complete this page. Continue to signature page

15. QUALIFYING INFORMATION

Provide complete details to all "Yes" answers in the Details section below.

Has any proposed insured been diagnosed with or treated within the past 10 years by a licensed member of the medical profession for any of the following diseases or illnesses:	Proposed Insured		Any Other Insured(s)	
	Yes	**No**	**Yes**	**No**
a) Tuberculosis, sleep apnea, sleep disorder, pneumonia or sarcoidosis?	☐	☐	☐	☐
b) Colon polyps, jaundice, liver disease, hemochromatosis, cirrhosis, alcoholic liver damage, pancreatitis, polycystic kidney disease, kidney stones, or any other disease of the liver or kidneys?	☐	☐	☐	☐
c) Epilepsy, neuropathy, excessive bleeding, diminished immunity, congenital heart defect, murmurs or malformations?	☐	☐	☐	☐
d) Rheumatoid arthritis, vasculitis, ankylosing spondylitis, osteoporosis, or any other disease of the bone or connective tissue?	☐	☐	☐	☐
e) Gestational diabetes, weight loss or weight gain of more than 10 pounds?	☐	☐	☐	☐
f) Depression, anxiety, attention deficit disorder, posttraumatic stress, or any other emotional or mental illness?	☐	☐	☐	☐
g) any medical disorder not listed above?	☐	☐	☐	☐
Has the proposed insured:				
h) within the past 3 years, engaged in or plan to engage within the next 2 years in motor sports (land or water), mountain climbing, rock climbing, skydiving, parachuting, hang gliding, or scuba diving? (If "Yes," please complete Hazardous Sports Questionnaire.)	☐	☐	☐	☐
i) within the past 3 years, been convicted of any motor vehicle violations? (If "Yes," indicate number below.)	☐	☐	☐	☐
j) within the past 5 years, had abnormal results on any blood test, urinalysis, EKG, exercise stress test, cardiac catheterization, cardiac ECHO, ultrasound, CT or MRI scan, or mammogram, excluding those tests related to the Human Immunodeficiency Virus (AIDS Virus)?	☐	☐	☐	☐
k) within the past 7 years, filed for bankruptcy?	☐	☐	☐	☐
l) had an affiliation with the Reserves, National Guard or Active Military Services? (If "Yes," please complete Military Questionnaire)	☐	☐	☐	☐
m) had any family history (parents/siblings) of a death from diabetes, heart disease or cancer prior to the age of 65?	☐	☐	☐	☐
n) any intention of traveling or residing outside the United States or Canada within the next 2 years? (If "Yes," please complete Foreign Travel Questionnaire.)	☐	☐	☐	☐

16. DETAILS

Provide details here to any qualifying information questions answered "Yes."

Question #/Insured name	Details/Diagnosis/ Condition/Dates	Medication/Treatments	Physician name

Contract number _____
(Home office use only)

17. DISCLOSURES AND SIGNATURES

OWNER SOCIAL SECURITY/TAX ID NUMBER (SSN/TIN) CERTIFICATION - By signing this application, I certify under penalties of perjury that: (1) the Social Security/Tax ID number shown is correct, and (2) I am not subject to backup withholding due to failure to report interest or dividend income, and (3) I am a U.S. Person (U.S. Citizen, U.S. Resident Alien or other U.S. Person as defined by the Internal Revenue Service (IRS)).

☐ By checking this box, and signing below, I am deleting statement (2) above from this certification.

SSN/TIN Section only | The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

LIBERTY'S LIVING BENEFIT DISCLOSURE ACKNOWLEDGMENT - I acknowledge that Liberty's Living Benefit, an Accelerated Death Benefit, is available to the primary proposed insured under this contract for initial death benefits greater than or equal to $20,000, and I have read and received the disclosure pertaining to Liberty's Living Benefit.

☐ Check here to exclude Liberty's Living Benefit.

AUTHORIZATION TO OBTAIN INFORMATION - I AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy benefit manager, other medical or medically-related facility, insurance or reinsuring company, MIB, Inc. (MIB), consumer reporting agency, employer or former employer to give to Liberty Life Assurance Company of Boston (the Company), its employees and reinsurers any information about my: physical or mental condition, character, general reputation, habits, finances, insurance history, occupation, and hobbies. I also authorize the Company to obtain an investigative consumer report on me. This authorization applies to all types of information, including but not limited to information regarding HIV infection, AIDS, mental health and substance abuse. I also authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. I AM AWARE that the Company will use this information to determine if I am eligible for insurance or for benefits under an in-force policy. I am aware that the Company may give this information to its reinsurers, MIB, other persons or entities that perform services related to my application or claim, or as may be authorized or required by law. I understand information obtained with my authorization may be re-disclosed as permitted or required by law and may no longer be protected by the federal privacy laws. I AGREE that this authorization shall be valid for 2 years from the date appearing below my signature and that I have the right to revoke this authorization at any time by written notification to the Company. I agree that a copy will be as valid as this original. I MAY ASK for a copy of this form. I RECEIVED the Notice of Information Practices and the notices required by the Federal Fair Credit Reporting Act and MIB.

AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER - By signing this application, I authorize Liberty Life Assurance Company of Boston (the Company) to initiate a one-time or monthly withdrawal from the specified account of the financial institution indicated, for the purpose of meeting premium payment obligations. I understand: (1) No premium is considered paid until each debit is accepted by the financial institution. (2) Any debit not honored may be subject to a return fee from the financial institution. (3) For any debit not honored, the Company may attempt to debit the account again up to three days later for the amount due. (4) The Company will not incur liability as a result of a debit that is not honored by the financial institution. (5) The payor or the Company may terminate this agreement at any time by written notification from one party to the other party.

AUTHORIZATION FOR CREDIT CARD PAYMENT - By signing this application, I authorize Liberty Life Assurance Company of Boston to initiate a one-time charge to the credit card shown on the application for the purpose of meeting premium payment obligations. I agree not to contest this charge upon approval of this credit card transaction.

INSURING AGREEMENT - I(We) declare that all statements and answers given in this application are true and complete to the best of my(our) knowledge and belief. I(We) also agree that: (1) no agent/insurance producer has the authority to determine insurability, waive any rights or requirements of the Company, or make or modify any contract of insurance; (2) no information obtained by any such person will bind the Company unless set out in writing in a part of the application; (3) all statements and answers given in this application will form the basis for, and become part of, any contract of insurance issued by the Company under this application; and (4) no insurance will take effect on the basis of this application unless: (a) the full first premium has been paid; and (b) the contract has been delivered to and accepted by the applicant without a change in the insurability status of the proposed insured.

Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, submits an application or files a statement of claim containing any false, incomplete or misleading information may be subject to criminal or civil penalties.

X _____
Proposed Insured/Guardian Signature

X _____
Owner Signature

X _____
Joint Owner Signature (if applicable)

X _____
Payor Signature (if applicable)

X _____
Agent/Insurance Producer Signature (as witness)

Signed in: _____ on _____
City and State Date

Liberty Life Assurance Company of Boston
[Service Center, 100 Liberty Way, Dover, NH 03820]

[Contract number ____________________
(Home office use only)]

Supplemental Application for Individual Life Insurance

If additional space is needed, complete an additional supplemental application.

PROPOSED INSURED

Name (First, Middle, Last) ____________________ Birth date ____________

BENEFICIARIES

All designated beneficiaries will be considered primary, sharing equally, unless otherwise indicated.

☐ Primary ☐ Contingent ________% Relationship to insured ____________________
Name (First, Middle, Last)/Entity ____________________ Birth/Trust date ____________
Residence address (Street, City, State, ZIP) ____________________
Mailing address (If different) ____________________
Telephone number ____________________ Social Security/Tax ID number ____________________

☐ Primary ☐ Contingent ________% Relationship to insured ____________________
Name (First, Middle, Last)/Entity ____________________ Birth/Trust date ____________
Residence address (Street, City, State, ZIP) ____________________
Mailing address (If different) ____________________
Telephone number ____________________ Social Security/Tax ID number ____________________

☐ Primary ☐ Contingent ________% Relationship to insured ____________________
Name (First, Middle, Last)/Entity ____________________ Birth/Trust date ____________
Residence address (Street, City, State, ZIP) ____________________
Mailing address (If different) ____________________
Telephone number ____________________ Social Security/Tax ID number ____________________

☐ Primary ☐ Contingent ________% Relationship to insured ____________________
Name (First, Middle, Last)/Entity ____________________ Birth/Trust date ____________
Residence address (Street, City, State, ZIP) ____________________
Mailing address (If different) ____________________
Telephone number ____________________ Social Security/Tax ID number ____________________

☐ Primary ☐ Contingent ________% Relationship to insured ____________________
Name (First, Middle, Last)/Entity ____________________ Birth/Trust date ____________
Residence address (Street, City, State, ZIP) ____________________
Mailing address (If different) ____________________
Telephone number ____________________ Social Security/Tax ID number ____________________

☐ Primary ☐ Contingent ________% Relationship to insured ____________________
Name (First, Middle, Last)/Entity ____________________ Birth/Trust date ____________
Residence address (Street, City, State, ZIP) ____________________
Mailing address (If different) ____________________
Telephone number ____________________ Social Security/Tax ID number ____________________

Contract number _____ (Home office use only)

CHILDREN'S PROTECTION

"Children" means all children, step-children, and legally adopted children of the Insured who have not reached their 18th birthday. Insurance will not be provided on any child until 15 days after birth.

Name (First, Middle, Last) _____ ☐ Male ☐ Female

Birth date _____ Birthplace (State, Country) _____ Height (ft, in) _____ Weight (lbs) _____

Name (First, Middle, Last) _____ ☐ Male ☐ Female

Birth date _____ Birthplace (State, Country) _____ Height (ft, in) _____ Weight (lbs) _____

Name (First, Middle, Last) _____ ☐ Male ☐ Female

Birth date _____ Birthplace (State, Country) _____ Height (ft, in) _____ Weight (lbs) _____

COVERAGE/REPLACEMENT

If applicable, complete and submit replacement forms.

If "Yes," replaced policy type ☐ Life ☐ Annuity ☐ Select if Section 1035 exchange

Company name _____ Contract number _____

If "Yes," replaced policy type ☐ Life ☐ Annuity ☐ Select if Section 1035 exchange

Company name _____ Contract number _____

If "Yes," replaced policy type ☐ Life ☐ Annuity ☐ Select if Section 1035 exchange

Company name _____ Contract number _____

Coverage/Replacement Details

Question # Details

PHYSICIAN INFORMATION

Please provide physician information for proposed insured and any child insured(s).

Physician name _____ Facility name _____

Mailing address _____ Telephone number _____

Date and reason last seen _____

Physician of (provide insured's name) _____

Physician name _____ Facility name _____

Mailing address _____ Telephone number _____

Date and reason last seen _____

Physician of (provide insured's name) _____

DETAILS

Provide details here to any qualifying information questions answered "Yes."

Question #/Insured name	Details/Diagnosis/ Condition/Dates	Medication/Treatments	Physician name

SIGNATURES

X _____
Proposed Insured/Guardian Signature

X _____
Owner Signature

X _____
Joint Owner Signature (if applicable)

X _____
Payor Signature (if applicable)

X _____
Agent/Insurance Producer Signature (as witness)

Signed in: _____ on _____
City and State Date

Liberty Life Assurance Company of Boston

Statement of Variability

December 11, 2012

Form No: APP-2012139
Application for Individual Life Insurance

Variable information is indicated through the use of brackets. Brackets will not appear on the owner's printed contract.

Bracketed Field Name	Description of Variability
[Contract Number_____] (Home Office Use Only) Appears on all pages	This field is an administrative field. The field is intended to display the application or contract number that would change by application. This field may be used for other administrative purposes, moved to another location on the application or may be removed.
Service Center address	This address is subject to change.
Instructional Text	Text next to section headings e.g., 2. Owner, are instructional in nature and may be revised to other text to facilitate the completion of the application.
Alternate Addressee	Text in this field may be added/changed to request additional addressee information to process such request. (e.g., telephone number). The location within the section may change.
Select if Section 1035 Exchange	Text may be deleted, added, or changed for other replacement action.
Product Selection	Approved plans of insurance, product categories and instructions may be added, changed or removed.
Initial Payment [Type]	Payment options in this section may be deleted, added, or changed to other payment options.
Type of Credit card	Credit card options in this section may be deleted, added, or changed to other credit card options
Subsequent Payment [Mode]	Payment modes in this section may be deleted, added, or changed to other payment modes.
Instruction Bar (Page 5 heading)	This text is instructional in nature and may be revised to other text to facilitate the completion of the application, or may be removed.
Fraud Language	This text can change in the event fraud language requirements change
Administrative Data at bottom of each page	This field is to be used for administrative data. This field may also be moved to another location on the application or may be removed.
Bar Code field at bottom of each page	A bar code or other code may be used on the application. The location, size, or type of identifier is subject to change.
Revision Date at bottom of each page	The revision date is subject to change.

The form is submitted in final print and is subject to modifications in paper size, color, stock, binding, shading, borders, font type, size, and color, and changes that occur as a result of company adaptation to computer printing/typesetting.

Liberty Life Assurance Company of Boston

Statement of Variability

December 11, 2012

Form No: APP-2012139-O
Application for Individual Life Insurance

Variable information is indicated through the use of brackets. Brackets will not appear on the owner's printed contract.

Bracketed Field Name	Description of Variability
[Contract Number_____] (Home Office Use Only)	This field is an administrative field. The field is intended to display the application or contract number that would change by application. This field may be used for other administrative purposes, moved to another location on the application or may be removed.
Service Center address	This address is subject to change.
Instructional Text	Text next to section headings e.g., Proposed Insured, are instructional in nature and may be revised to other text to facilitate the completion of the application.
Select if Section 1035 Exchange	Text may be added/changed for other replacement information.
Administrative Data at bottom of each page	This field is to be used for administrative data. This field may also be moved to another location on the application or may be removed.
Bar Code field at bottom of each page	A bar code or other code may be used on the application. The location, size, or type of identifier is subject to change.
Revision Date at bottom of each page	The revision date is subject to change.

The form is submitted in final print and is subject to modifications in paper size, color, stock, binding, shading, borders, font type, size, and color, and changes that occur as a result of company adaptation to computer printing/typesetting.

SERFF Tracking #:	*LLAC-128822246*	***State Tracking #:***	***Company Tracking #:*** *APP-2012139 & APP-2012139-O*

State:	*Arkansas*	***Filing Company:***	*Liberty Life Assurance Company of Boston*
TOI/Sub-TOI:	*L07I Individual Life - Whole/L07I.101 Fixed/Indeterminate Premium - Single Life*		
Product Name:	*Life Application (Whole Life, Term, and UL)*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Flesch Certification 139.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Replacement Question Certification		
Comments:			
Attachment(s):			
Replacement Question Certification 139.pdf			

FLESCH CERTIFICATION

Liberty Life Assurance Company of Boston

I certify on behalf of the Company that the forms referenced below are in compliance with the readability requirements of the state.

The Flesch Reading Ease Test was applied to application APP-2012139 form in its entirety. In calculating this score we excluded the company name, address, form number, revision date, captions, subcaptions, required language, medical terminology, and defined terms.

The Flesch Reading Ease Test was applied to supplemental application APP-2012139-O form in its entirety. In calculating this score we excluded the company name, address, form number, revision date, captions, subcaptions, required language, medical terminology, and defined terms.

Flesch Statistics

APP-2012139	
Words	1871
Characters	10227
Paragraphs	419
Sentences	82
Flesch Reading Ease	**54.6**

APP-2012139-O	
Words	439
Characters	2680
Paragraphs	133
Sentences	7
Flesch Reading Ease	**52.9**

William J. Dauksewicz, CLU, ChFC, CPCU
Vice President and Manager
Individual Life Compliance
Liberty Life Assurance Company of Boston

December 11, 2012

Liberty Life Assurance Company of Boston

Form No: APP-2012139 Application for Individual Life Insurance
APP-2012139-O Supplemental Application for Individual Life Insurance

Replacement Question Certification

On behalf of Liberty Life Assurance Company of Boston, I certify that that the agent's replacement question will be included in a separate form.

December 11, 2012

William J. Dauksewicz, CLU, ChFC, CPCU
Vice President and Manager
Individual Life Compliance
Liberty Life Assurance Company of Boston
100 Liberty Way
Dover, NH 03820

Date